police officers, both past and present, who by their faithful and loyal devotion to their responsibilities have rendered a dedicated service to their communities and, in doing so, have established for themselves an enviable and enduring reputation for preserving the rights and security of all citizens. I further call upon all citizens to observe Staturday, May 15, as Peace Officers' Memorial Day in honor of those peace officers who, through their courageous deeds, have lost their lives or have become disabled in the performance of duty.

THE MEDICARE CHRONIC DISEASE PRESCRIPTION DRUG BENEFIT ACT OF 1999

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 13, 1999

Mr. CARDIN. Mr. Speaker, I rise today to introduce legislation that addresses one of the most pressing problems facing America's older and disabled citizens today—access to comprehensive medical care. Medicare, the federal health insurance program for the elderly and disabled, covers a large number of medical services, Inpatient care, physician services, skilled nursing facilities, and home health and hospice care are all covered by the Medicare program. Despite the success of this program in eliminating illness as a potential cause of financial ruin, the burden of high prescription drug costs remains a source of hardship for many beneficiaries.

When Congress created Medicare in 1965, prescription drugs were not a standard feature of most private insurance policies. But health care in the United States has evolved considerably in the last 34 years. Now most private health plans cover drugs because they are an essential component of modern health care. They are viewed as integral in the treatment and prevention of diseases. But Medicare, for all its achievements, has not kept pace with America's health care system. It's time for Medicare to modernize.

Because Medicare does not pay for prescription drugs, Medicare beneficiaries, 80% of whom use a prescription drug every day, must either rely on Medicaid if they qualify, purchase private supplemental coverage, join a Medicare HMO that offers drug benefits, or pay for them out-of-pocket.

Medicaid does provide prescription drug coverage. But nearly 60% of Medicare beneficiaries with incomes below the federal poverty level were not enrolled in Medicaid as recently as 1997. And even Medicaid enrollees with drug benefits must forgo some medications. For example, eleven state Medicaid programs have imposed caps on the number of prescriptions covered each month.

The drug coverage available through Medigap leaves much to be desired. Only 3 of the 10 standardized Medigap plans offer drug coverage, and the plans that do have limits on the benefits and high cost sharing. Two plans have caps of $1250, and the third has a cap of $3000. In addition, all three policies require that beneficiaries pay a 50% coinsurance for prescription drugs. The high cost of Medigap policies puts them out of reach for most low-to-moderate income Medicare enrollees. In my home state of Maryland, a 70 year-old beneficiary buying a Medigap policy with drug benefits would have to pay between $1100 and $3550 per year.

Some beneficiaries get drug benefits through employer-sponsored retiree plans. Although between 60 and 70% of large employers offered retiree health benefits in the 1980s, fewer than 40% do so today. Of these, nearly one-third do not provide drug benefits to their retirees.

So that leaves Medicare HMOs. Nearly one-quarter of Medicare+Choice enrollees—1.5 million beneficiaries—do not have drug benefits today. Nine of ten plans that do offer drugs impose annual caps, some of which are as low as $600. In fact, some seniors in Medicare HMOs are relying on pharmaceutical samples from their physicians to get sufficient supplies of medications. Twenty-five percent of enrollees with drug coverage pay a monthly premium to join the HMO, and these premiums are certain to rise next year. Last October, four of the eight HMOs offering Medicare coverage in Maryland exited the program, abandoning 34,600 seniors. In all but the metropolitan areas, only one HMO was left and it went from a zero premium to $75 a month.

Finally, the benefits offered by Medicare+Choice plans are not permanent. Because they are not part of the basic Medicare benefit package, which by law must be included in Medicare+Choice plans, drug benefits are considered ''extra'' and as such can change from year to year. On July 1, just 50 days from now, HMOs will submit their proposals to the Health Care Financing Administration for 2000. HCFA estimates that 16 million seniors, or 40% of all beneficiaries, will lack drug coverage as of next year.

All of these statistics make us painfully aware of the gaping hole in Medicare's safety net. This Congress can move now to patch it before more elderly and disabled citizens fall through. Today, Mr. Speaker, I am introducing legislation to accomplish this. My bill, the Medicare Chronic Disease Prescription Drug Benefit Act, recognizes the importance of preventive care and provides coverage for drugs that have been determined to show progress in treating chronic diseases. Why chronic diseases? Because the average drug expenditures for elderly persons with just one chronic disease are more than twice as high than for those without any chronic conditions. And because we know from years of advanced medical research that treating these conditions will reduce costly inpatient hospitalizations and expensive follow-up care. Furthermore, this bill addresses those beneficiaries who need assistance with their medications: a review of the Medicare+Choice program reveals that seniors who join HMOs—whom HMOs market to—are younger and healthier than those in fee-for-service Medicare. This tells us that the older, sicker seniors are not getting drug benefits.

My bill addresses their needs. It begins with five chronic diseases that have high prevalence among seniors and whose treatment will show improvement in beneficiaries' quality of life and reduce Medicare's overall expenditures. This bill provides coverage after an annual $250 deductible is met, with no copayment for generics and a 20% copayment for brand-name drugs. The Agency for Health Care Policy and Research will review available data on the effectiveness of drugs in treating these conditions, and based on AHCPR's review, the Department of health and Human Services will determine the drugs to be covered. Pharmacy Benefit Managers (PBM) under contract on a regional basis with the Health Care Financing Administration will negotiate with pharmaceutical companies to purchase these drugs and will administer the benefit.

This bill covers five major chronic conditions, but we know that there are others that should be covered as well. The legislation provides a process for the Institute of Medicine to determine the effectiveness of this benefit and the Medicare savings it produces, and to recommend additional diagnoses and medications that should be considered for coverage.

Mr. Speaker, modern medicine has the capability of doing extraordinary things. But no medical breakthrough, no matter how remarkable, can benefit patients if they can't get access to it. This bill is a matter of common sense: if Medicare beneficiaries can secure the medications they need, they will be able to managed their conditions, and will be much less likely to require extended and costly inpatient care. This legislation is a first step, a major step, toward making this happen. I urge my colleagues to join me in providing a solid package of prescription drug benefits that will modernize Medicare for the 21st century for the millions of Americans who depend on it.

HAPPY 100TH ANNIVERSARY LUTHERAN CHILD AND FAMILY SERVICE OF MICHIGAN

HON. JAMES A. BARCIA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 13, 1999

Mr. BARCIA. Mr. Speaker, nothing is more precious than our children, and nothing is more important than our families. An organization that celebrates and assists both of these assets is one truly worthy of recognition. I am very happy to tell you that this Sunday, May 16th, Lutheran Child and Family Service of Michigan will hold its 100th Anniversary Worship Service in Frankenmuth, celebrating the organization's founding on May 9, 1899, and its century of accomplishment.

A resolution adopted by the Saginaw Valley Pastors' Conference of the Lutheran Church, Missouri Synod, led to the establishment of Lutheran Child and Family Service of Michigan. It was a response to the need for assistance to children who were left homeless by a terrible fires in the Thumb area of Michigan. This was the initial chapter in a proud history of serving tens of thousands of Michigan's children and families through twenty-two service sites in the Lower Peninsula.

During this past century of championship, Lutheran Child and Family Service of Michigan was developed specialized foster care services to assist children with intensive treatment needs, and has become one of the largest providers of foster care services throughout Michigan. It is the largest provider of intensive in-home family preservation through its ''Families First'' program. It maintains three residential facilities throughout the state for adolescent women, emotionally and mentally impaired boys and girls, and its Lutheran Home in Bay City that provides treatment for adolescent boys. It is the largest private provider in Michigan in the placement of state wards into